

# Bridging Cultural Differences in Medical Practice

## The Case of Discussing Negative Information with Navajo Patients

Joseph A. Carrese, MD, MPH, Lorna A. Rhodes, PhD

**BACKGROUND:** Cultural differences between doctors and their patients are common and may have important implications for the clinical encounter. For example, some Navajo patients may regard advance care planning discussions to be a violation of their traditional values.

**OBJECTIVE:** To learn from Navajo informants a culturally competent approach for discussing negative information.

**DESIGN:** Focused ethnography.

**SETTING:** Navajo Indian reservation, northeast Arizona.

**PARTICIPANTS:** Thirty-four Navajo informants, including patients, traditional healers, and biomedical health care providers.

**MEASUREMENT:** In-depth interviews.

**MAIN RESULTS:** Strategies for discussing negative information were identified and organized into four stages. Assessment of patients is important because some Navajo patients may be troubled by discussing negative information, and others may be unwilling to have such discussions at all. Preparation entails cultivating a trusting relationship with patients, involving family members, warning patients about the nature of the discussion as well as communicating that no harm is intended, and facilitating the involvement of traditional healers. Communication should proceed in a caring, kind, and respectful manner, consistent with the Navajo concept *k'é*. Reference to a third party is suggested when discussing negative information, as is respecting the power of language in Navajo culture by framing discussions in a positive way. Follow-through involves continuing to care for patients and fostering hope.

**CONCLUSIONS:** In-depth interviews identified many strategies for discussing negative information with Navajo patients. Future research could evaluate these recommendations. The approach described could be used to facilitate the bridging of cultural differences in other settings.

**KEY WORDS:** cultural differences; Navajo patients; negative information; cross-cultural ethics.

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*New information can and must be introduced into existing frameworks of health and illness, but this can be done in a meaningful way only when information about the target audience is retrieved first and then incorporated into the clinical message to be sent.*

J. Carey Jackson et al.<sup>1</sup>

In our pluralistic society, physicians often care for patients whose cultural, religious, or social backgrounds differ from their own. Several studies document considerable variety in patient values, views, and behaviors related to health and health care.<sup>2-14</sup> Unattended to, cultural differences between doctors and patients may result in conflict, decreased patient satisfaction, misdiagnosis, or suboptimal outcomes.<sup>6,15-17</sup> Conversely, evidence exists that a culturally competent approach to health care will achieve better outcomes.<sup>18</sup>

This study addressed the specific issue of discussing negative information with Navajo patients. News of a poor prognosis and the risks of an intervention are examples of negative information. Previously we showed that a high percentage of Navajo informants considered discussion of negative information to be a dangerous violation of traditional Navajo values.<sup>19</sup> Because Navajo patients receiving medical care in Western hospitals and clinics are routinely exposed to negative information through the practices of informed consent, truth telling, and advance care planning, we wanted to learn how providers should approach such discussions in a culturally sensitive way. In an earlier article, we reported broadly on the nature and extent of the differences between the culture of Western biomedicine and traditional Navajo culture on the topic of discussing negative information.<sup>19</sup> In this article, we report specific, practical strategies for discussing negative information and in turn attempting to bridge those cultural differences.

## METHODS

The methods used in this study were presented in an earlier article.<sup>19</sup> We refer readers to the methods section of that study for details, especially regarding additional information about study site, sampling strategies, trustworthiness, and human subjects approval; here we will summarize the major methodologic points.

The study was a focused ethnography,<sup>20</sup> and it was conducted on the Navajo Indian Reservation, located in

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Address correspondence and reprint requests to Dr. Carrese: Division of General Internal Medicine, Johns Hopkins Bayview Medical Center, 4940 Eastern Ave., Baltimore, MD 21224 (e-mail: jcarrese@JHMI.edu).

the “four-corners” area of the southwestern United States, between 1993 and 1995. Thirty-four Navajo informants (20 patients, 6 traditional healers, and 8 biomedical health care providers), with a mean age of 60 years, were identified by a combination of purposive and network sampling.<sup>21</sup> Because of their familiarity with both Navajo culture and Western biomedical culture, Navajo biomedical health care providers were uniquely positioned to identify practical strategies for discussing negative information with Navajo patients.

In-depth interviews,<sup>22</sup> which were audiotaped and then transcribed, lasted 1 to 2 hours and were conducted by the principal investigator (JAC). During the course of the interviews, informants were invited to share their views and advice about discussing negative information.

Data analysis followed an “editing analysis style.”<sup>23</sup> The transcripts were read carefully and interpreted. Several concerns and suggestions related to the problem of discussing negative information with Navajo patients were identified. Findings were categorized and associations between findings were examined. Certain categories logically clustered together; this led to the four-stage approach presented in the “Results” section.

The following are some of the steps taken to ensure trustworthiness<sup>24</sup> of the study’s findings: review of interpreter performance, independent coding of a sample of the transcripts, involvement of an anthropologist expert in Navajo culture, presentation of the findings to members of the Navajo community for their feedback, and critical review of the manuscript by the Committee on Research and Publications, Navajo Division of Health, Navajo Nation, Window Rock, Ariz.

## RESULTS

Analysis of the transcripts generated a four-stage approach and many practical suggestions for discussing negative information with Navajo patients. In presenting the data, we use as examples representative quotes from the transcribed interviews. The quoted speakers are all Navajo, and they include three categories of informants: patients, traditional healers, and Western biomedical health care providers. Quoted informants are identified by category either preceding or following each quotation.

### Assessment

Informants suggested that physicians should assess whether patients are willing to participate in a discussion that involves negative information:

*I think you have to assess individuals. You can’t approach it the same way each time. You have to make that assessment: How much is this patient willing to deal with it? Is it going to be, “You don’t talk about it”? And if that’s what it is, then you may have to go with that. (biomedical health care provider)*

Another point made was the importance of assessing the appropriate timing of any such discussion:

*Generally I like getting some feedback from the patient to help gauge their readiness to receive the information. (biomedical health care provider)*

### Preparation

Informants were concerned that patients and their family members be prepared before health care providers disclose potentially upsetting information to them. Informants offered several suggestions, including (1) establishing a trusting relationship, (2) facilitating the involvement of family members, (3) warning patients about the nature of the discussion and communicating to them that no harm is intended, and (4) facilitating the involvement of traditional healers if patients desire it.

To begin with, informants spoke about the importance of establishing a relationship and building rapport as the first step in setting the stage for discussing negative information:

*It is very important because if you just tell the patient right off the bat without setting the stage, the patient might get very upset and angry and then withdraw. He may not want to talk to the doctor, nurse, or social worker anymore. So I mainly establish a rapport with the patient, a relationship with the patient. Once you establish that good rapport with the patient, then you can work together with them. (biomedical health care provider)*

Similarly, informants commented on the importance of building trust, of getting to know patients, and in turn becoming known, issues of particular concern for non-Navajo health care providers who have arrived recently on the reservation.

*Let’s say somebody has a problem and an outside person comes in—like maybe you—you have good intentions, but they don’t know you. So they’re not going to put their complete faith in you. The thing is to try to get them to know you, and you have to know the people; you have to know their ways, and you have to know their customs. That way you can earn their trust and win their confidence. (traditional healer)*

Another aspect of preparation is inquiring about and facilitating the involvement of family members, who are usually present for important discussions and play a prominent role in decision making.

*Some of them will say, “Before you tell me, can you please tell my sister or my children. I want them to be present before you tell me.” Usually, patients will say that if they know that the problem is serious. (biomedical health care provider)*

*For this particular family, a young couple, before any major decisions could be made, we had to have the grandmother come down. (biomedical health care provider)*

Several informants suggested that patients be warned about the nature of what would be discussed, making it

clear that no harm was intended toward the patients or their relatives by the impending discussion.

*I think we have to find ways of presenting information that is not upsetting to the patients. Like prefacing our statements with "The information I want to give you is a very difficult subject. It's difficult for me to give you the information, and it may be difficult for you to hear it. But both of us agree that we need to discuss this. And I don't wish you misfortune or want anything bad to happen to you, but here's the situation . . ." And then go into your subject matter that has to do with giving information about a disease that's incurable, or working with a dying patient, or discussing advance directives, or anything. You just have to get them prepared. (biomedical health care provider)*

Protective prayers or ceremonies (with a traditional healer, a Native American Church roadman, or a representative of another spiritual or religious group) are other measures to consider in preparing patients for a discussion about potentially upsetting or harmful information. One traditional healer said the following:

*Information can scare, or startle, or make things worse. I recommend having prayers before going to the hospital to prepare them and protect them from the information.*

## Communication

Informants identified several issues for consideration when communicating information to patients, including (1) communicating information in a caring, kind, respectful manner; (2) not rushing the interaction; (3) having a positive focus; (4) referring to third parties rather than to the patient directly; and (5) reviewing the patient's story relative to the issues at hand.

Informants noted that compassion, caring, kindness, and respect are especially important when discussing negative information.

*Like in any culture, it's important to show patients that you care, and that you respect them. That's all they request, that's all they need. (biomedical health care provider)*

*You've got to be good to people. You've got to have understanding and patience and compassion. Then you have a good working relationship with people, and they listen. (patient)*

As providers begin to communicate, they are advised to avoid rushing. Taking time to be with patients and to discuss information in a deliberate, unhurried manner is a general recommendation that is particularly important when discussing serious topics.

*When you deliver bad news, just making that extra minute, or taking an extra 2 minutes, just taking time to sit and not running out after saying: "Okay. Cancer. Sorry. I'll refer you." Without any comment about seeing the patient back again, seeing how things are going, or maybe seeing if there's something else you could help with. Even just offering. That shows you have respect for them. (biomedical health care provider)*

Informants urged providers to respect the power of language in traditional Navajo culture by focusing on the positive as much as possible.

*If you say, "This medicine is for your high blood pressure, and you've got to take it like this, and if you don't one of these days you're going to get worse, and maybe a year later or two you're going to be dead," then right there, that guy's going to back off from you. That's the negative aspect. Tell him instead, "If you follow this example, you will get better, you will feel better, you will feel good." Mention the positive thing. That's what people want to hear. (traditional healer)*

Informants advised providers to be indirect when disclosing information about potential complications and risks by making reference to a (hypothetical) third party rather than directly linking these possibilities to the patient.

*When I speak with Navajo people about conditions, illnesses, outcomes, I don't speak to them directly, I do it in the third person. For example: "You know some people have this condition, and this may happen to them. If we do this test to check for meningitis, there's always the possibility of bleeding or infection. Some people may have had those things happen to them." That's how I teach and talk to people: "Some people have these troubles." It's more acceptable; you're not seen as wishing things on them. (biomedical health care provider)*

Finally, as doctors communicate information, informants suggest recounting the patient's story.

*First I explain to them what they were feeling, the symptoms. I say, "You were having shortness of breath; you were feeling nauseated and all these things. And you wanted to understand what was causing that." Then they usually say, "Yes". So then I explain: "This is what you have gone through: the procedures, what was done. This is what was done to find out just what is causing all this. Now we know what is causing this." I will explain all that to the patient, taking it very slowly, step by step, to make sure that they really do understand. Then you finally get to the diagnosis: "The doctor has determined that this is the diagnosis." (biomedical health care provider)*

*You just tie in pretty much everything that you know about the illness that helped you make the diagnosis. You review all these things before you tell them, "This is probably what it is." I think they accept that a lot more than saying right off the bat, "I think you have cancer." (biomedical health care provider)*

## Follow-through

The final stage addresses the physician's responsibility to the patient and the family once the discussion about negative information has transpired. Informants urge Western biomedical providers to continue to care for patients and communicate hope. A patient relayed the following:

*I get the idea [from the hospital] that there's nothing more to be done now. But I still have hope. I still feel that there is something that needs to be done. So I'm going to another hospital with my daughter.*

A family member said:

*The nurses and doctors may talk in a manner that the patient's not going to make it . . . but I feel as a family member we have to have a positive attitude that that's not going to happen and you try your best in your own traditional ways with the help from your relatives.*

A traditional healer noted:

*So this is how I help people. Even though they are at the end of their days, on the verge of leaving mother earth, there are ways to help that individual, and that's my job, my duty.*

## DISCUSSION

Cultural differences exist between physicians and their patients in the United States, and are likely to increase given the projected demographic trends over the next several decades.<sup>25</sup> In order to achieve optimal medical care, it will be important to find ways to bridge cultural differences between doctors and patients.

We examined in-depth one cross-cultural problem: discussing negative information with Navajo patients. Using a qualitative methodology, we sought to achieve a deeper understanding of the study issues from the perspective of our informants. This article reports the opinions and suggestions of those informants, based on their experiences and insights. Several practical strategies were identified, and they separated logically into four different stages: assessment, preparation, communication, and follow-through.

A critical issue addressed by the assessment step is that although some Navajo patients may be willing to discuss negative information, many may be troubled by such discussions, and others may be unwilling to have such discussions at all. Providers are cautioned against single-mindedly focusing on getting patients to talk about, for example, advance care planning, using the proposed strategies to accomplish this. Rather, the primary concern should be whether or not individual patients want to discuss advance care planning in the first place; if they do, attention should then shift to culturally respectful and competent ways of having such discussions.

The strategies presented in the steps dealing with preparation and communication correlate to some degree with established knowledge and principles of effective doctor-patient communication.<sup>26</sup> Yet, while study findings overlap with current approaches to doctor-patient communication in a general way, important differences exist. For example, the specific preparation strategy "warn patients that you intend no harm when discussing negative information" is not typically recommended in doctor-patient interactions, but makes sense in this study setting. In this regard, our findings suggest local solutions to local problems.

Similarly, when health care providers communicate information, they are advised to demonstrate compassion, caring, kindness, and respect. This constellation of quali-

ties approximates the Navajo concept *k'é*, which means "kindness, love, cooperation, thoughtfulness, friendliness, and peacefulness."<sup>27</sup> Though it is particularly important among relatives, in traditional Navajo society *k'é* is the ideal that orders all social relationships.<sup>27</sup> As such, *k'é* could be viewed as the ideal in doctor-patient relationships as well. Understanding this may serve to inform (and possibly motivate) health care providers about how to best interact with their patients.

The final stage urges providers to continue to care for patients and foster hope, which is consistent with the traditional Navajo concept *hózhó*, "thinking and speaking in the Beauty Way."<sup>28</sup> In the Navajo way there is always something to be done.

A general point that follows from these findings is that health care providers should not assume that all patients from a particular group or culture are of the same mind. Culture is not a "reified structure that causes people to act in certain ways."<sup>29</sup> Often there is significant intracultural variation in values and behaviors, and ultimately individual patients (with more or less input from their family) make decisions about their health care.<sup>6</sup> It would be a mistake to take information from this article and uncritically apply it to particular patients without knowing the individual patients and their preferences.

At the same time, any group may have characteristics and views that hold for a significant portion of the people in that group but might be difficult for those outside the group to appreciate or even imagine. Although not without risks,<sup>30</sup> the kind of research represented by this study can expand the imagination and knowledge base of doctors encountering situations and caring for patients unfamiliar to them. Thoughtful and selective application of such research findings should be, on balance, of benefit to patients because, given the study approach, the recommendations are grounded in patients' values and experiences.<sup>18</sup>

This study has some limitations. It was a qualitative study of a relatively small number of informants; therefore, caution should be exercised in generalizing the study's findings to patients beyond our informants. Also, any claim about the effectiveness of the proposed strategies must await further evaluation. However, on the basis of several presentations of these findings to audiences of Navajo and non-Navajo health care providers who care for Navajo patients, the findings have strong face validity. In at least one clinical setting, this model has been used for staff training.

Attempting to bridge cultural differences can be difficult. Cross-cultural differences can be profound and may defy good-faith efforts toward understanding and resolution. Solutions may be partial; at times efforts are unsuccessful. One of our informants offered this bit of advice with respect to our efforts to find "the" answer and thereby "solve" the problem we were examining:

*You are fishing for something that is solid, you are trying to find a solid answer. And in this case you won't find*

*anything real solid. It has to do with a little bit of this and a little bit of that.*

The proposed communication strategies, gleaned from our informants, could be viewed as "a little bit of this and a little bit of that."

In conclusion, cultural differences are common in medical practice in the United States. We have demonstrated that examination with a qualitative methodology can lead to a deeper understanding of these differences, as well as generation of practical strategies for responding to them. The proposed strategies may help health care providers approach and discuss in a culturally sensitive way with willing Navajo patients information that might otherwise be regarded as harmful. Future research could focus on evaluation and modification of the specific recommendations made in this article. Finally, health care providers who are encountering problems that result from cultural differences in other settings could use the methodologic approach described in this paper to begin understanding and bridging those differences.

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